SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

POLICY AND PROCEDURE MANUAL

Section: Human Resources Policy Number: 34 Subject: **Credentialing and Privileging of Licensed Independent Practitioners**	Effective Date: 6/25/07 Last Revision Date: 2/12/10 Page: 1 of 10

Policy

It is the policy of Shiawassee County Community Mental Health Authority (SCCMHA) to ensure that the credentials of licensed independent practitioners are verified and that clinical privileges are granted, as appropriate to the clinician's practice level, in order to ensure that consumers receive the highest quality of care.

Purpose

The purpose of the policy is to establish processes for the verification of credentials and to establish the processes for the granting of clinical privileges, including temporary privileges.

Applicability

This policy applies to all SCCMHA provider operations.

Definitions

For the purposes of implementing the policy, the following definitions are to be used:

Licensed Independent Practitioner (LIP): A licensed independent practitioner is a licensed physician or fully licensed psychologist.

Clinical Privileges (also "Clinical Responsibilities"): Authorization granted by the appropriate authority (for example, a governing body) to a practitioner to provide specific care services in an organization within well-defined limits, based on the following factors as applicable: license, education, training experience, competence, health status, and judgment.

Credentialing: The process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide client care services in or for a health care organization.

Credentialing and re-credentialing will be conducted on the following professionals:

- Physicians
- Physician Assistants
- Psychologists (Licensed, Limited Licensed, Temporary Licensed)
- Counselors (LPC)
- Social Workers (Licensed Masters, Licensed Bachelors, Limited Licensed or Social Services Technicians)
- Licensed Professional Counselors
- Nurse Practitioners
- RN and LPN
- Occupational Therapists or OTA
- Physical Therapists or PTA
- Speech Pathologists

Application for Network Participation and Temporary Clinical Privileges Procedures

Persons interested in providing clinical services as a licensed independent practitioner (LIP) must complete an application form and submit it to the designated Shiawassee County Community Mental Health service program department. The provider must sign and date the application. The application will address the following:

- Professional or Medical Licenses and Sanctions
- Prescribing Licenses (including narcotics and other drug control licenses
- Current Board Certifications or highest level of credential attained
- Current Malpractice Insurance Coverage (minimum levels of insurance are defined in the contract between SCCMHA and the Licensed Independent Practitioner)
- Work history for the prior five years
- Absence of any illegal drug use
- Any history of loss or limitation of privileges or disciplinary action
- Malpractice History - minimum of five year history
- Internships, Residencies and Fellowships
- Peer References (three references are required and may not be individuals in the same practice setting as the applicant practitioner)
- Work History and Affiliations for the past five years
- Hospital Privileges
- Continuing Medical Education (as required by State Licensing Board)
- Official College or University Transcripts
- Medicare Sanctions/Medicaid Sanctions
- Disciplinary status with a regulatory board or agency
- National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank

- Criminal Background Checks
- Documentation of graduation from an accredited school
- Attestation by the applicant of the correctness and completeness of the application

In the event that temporary clinical privileges are being requested, a letter of request from the LIP delineating the population(s) to be served and the services or procedures to be preformed is required prior to granting temporary privileges.

Temporary Privileges: Clinical privileges may be granted by the Chief Executive Officer (CEO) on a temporary basis, for up to 120 days, upon receipt of a completed application form, a five year prior work history, confirmation of appropriate licensure, Medicaid/Medicare sanctions and NPDB queries, while verification of credentials and other processes are pending. Temporary privileges may be granted on a one time only basis at initial request.

Incomplete applications are not processed and are returned to the person. Copies of all communications are maintained in the file of the interested person.

Credentialing Procedures

As a condition of placement in the agency, each applicant will be required to complete a Credentialing Application and Authorization for Background Checks. The written application must be complete, signed, and dated by the applicant. In addition this application must attest to the lack of present illegal drug use, history of loss or limitation of privileges or disciplinary action, and a summary of the applicant's work history for the prior five years. The Authorization for Background Checks will be used to obtain a criminal background check. In addition, a Child Abuse / Neglect Central Registry Clearance Check will be completed by all applicants to determine if the individual's name appears on the Central Registry for substantiation of child abuse or neglect.

SCCMHA certifies that in regards to requested information concerning the applicant, the agency will provide any and all required disclosures to the applicant. If an investigative consumer report (as defined by the Fair Credit Reporting Act) is compiled, SCCMHA will make a complete and accurate disclosure of the nature and scope of the investigation requested upon written request made by the applicant within a reasonable period of time after the receipt by him / her of the disclosure. This disclosure will be made in writing and mailed, or otherwise delivered to the applicant, no later than five days after the date on which the request for such disclosure was received from the applicant or such was first requested, whichever is later.

In addition, SCCMHA will not use information from the consumer report in violation of any applicable Federal or State equal opportunity law or regulation.

A credential file will be created and maintained by the Executive Assistant.

The credential file will contain, at minimum, the following:

- Complete provider network application
- Request for clinical privileges
- All primary source verification documentation (licensure or certification, board certifications, Medicare/Medicaid sanctions, etc.)
- All correspondence between the provider and SCCMHA
- The results of the credential review
- Recommendation from the Credentialing Committee

The following credentials will be verified as applicable to the position:

Malpractice History: The National Practitioner Data Bank (NPDB) will be accessed to verify professional liability claims history on all Physicians, Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, Professional Counselors, Clinical Psychologists, Occupational Therapists, Physical Therapists, Speech and Language Pathologists, and Certified / licensed Social Workers.

Current Malpractice Insurance Coverage: Practitioners will be required to maintain current malpractice insurance coverage and provide a copy of the face sheet for inclusion in the contract file. The privileging application will be reviewed to verify the dates and amount of coverage.

Board Certification: Board Certifications for MDs and DOs recognized by the American Board of Medical Specialties (ABMS) will be verified. Primary source verification is obtained from the internet source as www.abms.org.

Professional / Medical Degree / Internship / Residency / Fellowship: Inquiries will be made through the American Medical Association (AMA) Physician Master File for verification of a practitioner's medical school graduation and residency completion. Written verification from the Education Commission for Foreign Medical Graduates (ECFMG) will be required for primary source verification for Foreign Medical Graduates.

College or University Transcripts: A copy of college or university transcripts will be obtained from the primary source prior to employment for verification of degree(s).

Letters of Reference: All individuals applying for employment with the agency will be required to submit three letters of reference. These letters should come from individuals who are personally acquainted with the applicant's professional and / or clinical performance, have witnessed the use of the applicant's clinical judgment and technical skills, and witnessed demonstration of the applicant's current competencies in their flied of work.

State License Verification: Primary source verification of current licensure is conducted for all professionals and is obtained directly from the Michigan Department of Labor and

Economic Growth website. Human Resources or appropriate designee will confirm current licensure, maintain a copy of the license and verification in the credentialing file and, prior to expiration, notify the individual to supply a copy of the renewed license.

Individuals contracted in positions requiring a state license will be responsible for the renewal of their license. Those who fail to maintain a current license will not be able to continue working with the agency until proof of renewal is obtained. A copy of the renewal application or check stub may be presented as proof of renewal.

The Executive Assistant will complete the following background checks on all independent contractors.

Medicaid Fraud: The website of the Office of Inspector General (OIG) will be accessed prior to approval of providers for all clinical positions, and every two years thereafter to ensure that records are clear of Medicaid fraud and / or patient abuse. A negative report from OIG will prohibit this person from being contracted with our agency. Compliance with Federal regulations prohibits contracts of individuals excluded from participation under either Medicaid or Medicare.

Criminal History: A criminal history background check (convictions only) will be completed through the Michigan State Police Central Records Department website on all new providers prior to approval for contracting. Every two years thereafter, a background check will be completed on all clinical providers.

Protective Services: A protective services background check will be obtained from the Department of Human Services prior to approval of a contract for all clinical positions and every two years thereafter. If the applicant appears on the Central Registry for substantiation of child abuse and / or neglect, the individual will not be eligible to work with children at our agency.

Credentials Verification Options: The type of credentials verified depends on the type of practitioner. The following categories of investigation occur for most licensed independent practitioners' credentials verifications. Typically, static historical information is verified only at the time of initial credentialing.

- Professional or Medical Licenses and Sanctions
- Prescribing Licenses (including narcotics and other drug control licenses
- Current Board Certifications or highest level of credential attained
- Current Malpractice Insurance Coverage (minimum levels of insurance are defined in the contract between SCCMHA and the Licensed Independent Practitioner)
- Malpractice History - minimum of five year history
- Internships, Residencies and Fellowships
- Peer References (three references are required and may not be individuals in the same practice setting as the applicant practitioner)
- Work History and Affiliations for the past five years

- Hospital Privileges
- Continuing Medical Education (as required by State Licensing Board)
- Medicare Sanctions/Medicaid Sanctions
- Disciplinary status with a regulatory board or agency
- National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank
- Criminal Background Checks
- Documentation of graduation from an accredited school
- Lack of present illegal drug use.
- Any history of loss or limitation of privileges.

The Executive Assistant reviews the credential file for completeness, noting any areas where credentials are in question. The Executive Assistant will forward the packet to the Credentialing Committee to review credentials.

- Questionable Credentials or Credentials not Verified: Where credentials are questionable or not confirmed, the Credentialing Committee will not credential the LIP. The non-credentialing decision is communicated to the LIP in writing by the Chief Executive Officer within 31 days of the date of application. The LIP is given the opportunity to respond to and reliably correct and questionable or unconfirmed information.

- Credentials Verified: When credentials are in order, the Credentialing Committee will evaluate and take action.

The credentialing/re-credentialing process will not discriminate against:

- A healthcare professional solely on the basis of license, registration or certification.

- A healthcare professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

Compliance with Federal regulations prohibits employment or contracts with providers excluded from participation under either Medicaid or Medicare. SCCMHA will endeavor to report to appropriate authorities (i.e. MDCH, the provider's regulatory board or agency, the Office of Attorney General), individual practitioner conduct which results in suspension or termination of provider from the agency's network. All SCCMHA providers will adhere to all the expectations of Chapter 13, Corporate Compliance policy and procedure; Administrative and Operational Practices; Prohibited Affiliations and / or Exclusion and Conviction and sign a formal attestation to that effect.

Privileging Procedures

Application: The Provide Network Application Form and a written request for clinical privileges must be provided and signed by the Licensed Independent Practitioner

delineating privileges requested, populations to be served and procedures to be performed. Privilege categories are gender, age and disorder population specific as well as procedure specific.

After credentials are verified pursuant to the procedures above, the Credentialing File Checklist or the Privileging File Checklist completed by the Executive Assistant is given to the Credentialing Committee.

Credentialing Committee: The CEO will appoint an ad hoc Credentialing Committee to serve as the credentialing panel. The Credentialing Committee will also include a provider representative appointed by the CEO. This committee shall review the recommendations and information submitted by the LIP and primary source verification reviewed by the Executive Assistant, and also consider other practice information, including but not limited to site reviews, case reviews and other available documentation about the performance and practices of the LIP.

The Credentialing Committee will judge the merits of the application for provider network membership and competency to perform the services for which privileges are requested to the population(s) identified on the application. This is accomplished with the completion of the Competency Checklist for Contract Providers form.

The Credentialing Committee shall make a written affirmative or negative recommendation to the Chief Executive Officer regarding the delineation and granting of clinical privileges.

Chief Executive Officer Recommendation and Board of Directors Action: The Chief Executive Officer will review and forward his/her recommendation to the Board. Only the Board of Directors may grant full clinical privileges.

Privileges Granted: If granted, provisional clinical privileges will be in effect for a period of one year. If granted, a renewal of clinical privileges previously granted are effective for two years. Communication regarding the privileging decision will be sent to the provider in writing within five days of the Board action.

Reapplication: Prior to the expiration, the clinician must reapply for privileges. At the time of re-application an update of information will be obtained during the credentialing process. A review of the following will be completed:

- Medicare/Medicaid sanctions
- State sanctions or limitations on license / registration / certification
- Beneficiary concerns (including grievances & complaints) and appeals information
- SCCMHA standards regarding productivity and related performance improvement issues

If clinical privileges are denied or revoked, the clinician may follow the appeal process as outlined below. The Board retains the right to approve, suspend or terminate providers with the SCCMHA.

Privilege Revocation or Suspension: Privileges to practice may be suspended at any time and at the discretion of the CEO pending the investigation of allegations of consumer abuse or neglect, negligence, malpractice, incompetence, violations of professional or Board ethics, loss of license, certification or registration, exclusion from Medicare or Medicaid, or any other circumstances which interferes with the practitioner's capacity to render professional services. The LIP will be notified of such action in writing.

Requests for Reconsideration or Appeal: Practitioners may ask for a reconsideration of decisions to deny, suspend, or terminate privileges.

- The request for reconsideration must be writing and must be filed with the CEO within ten (10) calendar days of receipt of the notice of action provided by the Board.

- The CEO may consult with the medical director and/or any other person who may have information bearing on the request for reconsideration.

- The request for reconsideration shall be reviewed by the Human Resources Committee of the Board at their next scheduled meeting and recommendation made to the entire Board for review and action.

    - Both the practitioner and the Board can be represented by advocates at this meeting.

    - Both the practitioner and the Board may present a reasonable number of witnesses at the meeting.

    - Both the practitioner and the Board may file written documents at this meeting.

    - The Board of Directors shall review the evidence presented and the recommendations of the Human Resources Committee of the Board and shall be solely responsible for determining the outcome of the appeal. Notice of the Board's determination shall be provided to the practitioner with ten (10) days of the review meeting.

Related Forms

Credentialing and Privileging Tracking Form
Provider Network Application Form
Clinical Competency Assessment Form

Competency Checklist for Contract Providers Form

References/Legal Authority

1. BBA 97 Regulation 438.12(a)(1) and 438.21(c)

2. JCAHO (1997) Comprehensive Accreditation Manual for Managed Behavioral Health Care, Management of Human Resources Standards HR 1-14, pages 548-553.

3. MDCH/PIHP Contract, Quality Assessment and Performance Improvement programs for Specialty Pre-Paid Health Plans, Pages 166-167.

4. CMS and HHA (2001) Proposed Rules regarding Medicaid Managed Care; 42 CFR Parts 400, 430, 431, 434, 435, 438, 440 and 447; 66 FR 32776; Sections 438.206, 438.214, 438.230

Approved by: Signed by Jerry Walden 02/12/10
Board Chairperson Date

Signed by Scott Gilman 02/12/10
Chief Executive Officer Date

Review/Revision Dates:

Date:	By:
12/17/07	Revisions, George Drozd
01/25/08	Revisions, George Drozd
10/08/08	Revisions, George Drozd
2/12/10	Revision from AAM audit
4/14/11	Reviewed by Human Resources Committee
4/12/12	Reviewed by Human Resources Committee
8/13/13	Reviewed by Human Resources Committee
07/24/14	Reviewed by Human Resources Committee
10/08/15	Annual Review by the Human Resources Committee